Legislative Testimony
Public Health Committee
HB5541 AAC Services Provided by Dental Professionals and Certification for Advanced Dental Hygiene Practitioner
Wednesday, March 21st, 2012
Jack Mooney, D.M.D.

Senator Gerantana, Representative Ritter, Senator Slossberg, Representative Lyddy, Senator Welch, Representative Perillo and fellow members of the Public Health Committee, my name is Dr.Jack Mooney, I am a private practicing dentist in Putnam Connecticut. I am the Chair of the CSDA's Access to Care Committee I suppose for the following reasons: I have over 700 Medicaid children and adults in my practice. I have participated in a Public/Private Partnership with Generations which is an FQHC based in Willimantic. I am a Home by One provider and also sit on the Mission of Mercy Steering Committee. I consider myself an "in the trenches" doctor with direct clinical experience with our state patients who desire Access. I also consider myself a student of Access for oral health by studying new workforce models both nationally and internationally.
ADHP is not a new concept. It was conceived in the Commonwealth Nations as a means to deal with a shortage of dentists. Connecticut does not suffer from this shortage. When comparisons are made to other medical providers such as APRN's please be cognizant that those scope expansions happened because of shortages of primary care providers and most importantly does not allow for surgical procedures to be performed. In Connecticut a vast majority of dentists are general practioners, also our own dental school at UCONN is expanding insuring that we will have enough general practioners for the foreseeable future.

I strongly encourage all on the Committee to read the comparison in scope between ADHP and a fully trained dentist. You'll notice that a dentist must take a pre-doctoral exam in college, go through four years of dental school which is accredited by the Council on Dental Accreditation (CODA), pass a national board exam, pass a regional board exam and a regional clinical exam, pass a DPH jurisprudence exam and be under regulatory oversight by the department of health before they are allowed to perform dental surgical procedures in our state. Practicing under the term "Collaborative agreements" ADHP circumvents this process of allowing individuals to practice surgical dentistry in the state. There is no CODA approved program for ADHP, no national or regional board, no independent assessment of the candidate's dental surgical skills and no definition on the administrative burden and costs of regulation this new practioner would place on the Department of Public Health. Being brutally honest it is an end run around the rightfully demanding scholarship to be allowed to perform dental surgical procedures and "minor tooth movements" in our state. It has also been mentioned that ADHP would provide a "career ladder" for hygienists. I would respectfully state that a career ladder already exists especially for women who today represent 60% of the students in dental school.

As a student of the Access conundrum I remain fascinated by the attention ADHP gets in this state. Internationally this model was created to deliver dental care to underserved populations. However, because of the associated educational costs of the program most of the Commonwealth nations that utilized ADHP were forced to adopt a different model with less scope. In our nation we have seen a lot promised but little delivered in terms of Access when rules governing hygienists were relaxed. In Colorado, hygienists have been allowed to open independent practices to deliver hygiene for the underserved and uninsured population for lower cost. Today there are less than thirty independently practicing hygienists in Colorado and most of those practices operate in the well to do suburbs in the state, the costs are similar to a hygienists operating in a doctors office and worse

there has been no affect on Access for the poor. In our state reimbursement guidelines were relaxed to allow our state hygienists to be reimbursed directly in Nursing homes. Today less than five do so. In the meantime a modest fee increase in Medicaid rates has made Connecticut a national model for dental care of the Medicaid population. Even the DPH scopes report to the Public Health committee states that there exists no evidence that ADHP will increase Access. It begs the question why would the state consider ADHP??

My passion as some of you know is making sure that any expansion of scope must make an impact on utilization for the underserved. We are all guilty of making assumptions of what and who this population is. One major assumption is that a lower cost to educate provider will translate to lower cost for services. However I see no example that this assumption is true. A few years ago a physician assistant saw my son in the ER. When I went to pay the fee for the visit I asked if the fee was the same to me patient/consumer even though the doctor didn't render treatment. The answer was yes. When I utilize the APRN in my doctor's office I still have to pay my co-pay and even though the insurance company reimburses the doctor less, I have yet to see my medical insurance decrease. When a dental cleaning is done in a dental office the fee is the same regardless of whether the doctor or hygienists provides the service. My point is that we as patient/consumers rarely see a fee reduction or premium reduction for utilizing paraprofessionals and the cost of services remains a huge barrier to Access.

There is also the assumption that ADHP's like APRN's will free the doctor up to perform more complex procedures. This is a fundamental misunderstanding between what occurs in a medical office and the realities of what occurs during dental surgical treatment. I believe I have the type of practice that many would think could benefit from an ADHP. I have plenty of private and poor patients and the chair space to accommodate one. However when studying the economics it makes little sense for me to hire someone who would have to be closely supervised when delivering treatment. Each time a surgical issue arises I would have to examine and adjust the treatment plan accordingly. I'm better off with another dentist or performing the procedure myself because we are trained to seamlessly treatment plan should issues arise. What about the cost to patients? In Minnesota patients do not get a discount because they are being served by their version of a dental therapist. The demographic group of the working poor will still be unable to access services because regardless of who provides the care the costs remain prohibitive

In closing, the creation of an ADHP makes little sense for this state. We have an adequate provider base and have seen historic gains in utilization for Medicaid. ADHP educational requirements falls short for the amount of increased scope asked for and where it exists it has failed to impact Access in a positive way. There is no evidence that costs to the patient would be reduced so its supposed effect on access will be negligible. The state has no mechanism to independently verify the competency of ADHP and no money in the budget to regulate them. Connecticut's Medicaid and working poor populations need models that will help them utilize dental services. ADHP is not that model.

Respectfully Submitted,

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